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COVID-19: Preliminary recommendations from the SFORL

French consensus on management of head and neck cancer surgery during COVID-19 pandemic

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ABSTRACT

In the context of the current pandemic, there is a need for specific advice concerning treatment of patients with Head and Neck cancers. The rule is to limit as much as possible the number of patients in order to reduce the risks of contamination by the SARS-Cov-2 virus for both patients and the caregivers, who are particularly exposed in ENT. The aim is to minimize the risk of loss of opportunity for patients and to anticipate the increased number of cancer patients to be treated at the end of the pandemic, taking into account the degree of urgency, the difficulty of the surgery, the risk of contaminating the caregivers (tracheotomy) and the local situation (whether or not the hospital and intensive care departments are overstretched).

1. Introduction

In the context of the current pandemic, there is a need for specific advice concerning treatment of patients with head and neck cancers.

This advice applies to both consultations and surgical procedures and is of course likely to change on a day-by-day basis according to how the epidemic develops, available technical resources and state of knowledge about the COVID-19 infection [1,2].

2. Consensus

2.1. Surgery

The rule is to limit as much as possible the number of patients in order to reduce the risks of contamination by the SARS-Cov-2 virus for both patients and the caregivers, who are particularly exposed in ENT. Indications for flexible nasal endoscopies and laryngoscopies, airway endoscopies, tracheotomies and endonasal surgical operations must be reduced to the absolute minimum.

This should of course take into account the degree of emergency, the difficulty of the surgery, the risk of contaminating of the caregivers (tracheotomy) and the local situation (whether or not the hospital and intensive care services are overstretched).

The aim is to minimize the risk of loss of opportunity for patients and to anticipate the increased number of cancer patients to be treated at the end of the pandemic.

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We can define 3 groups of patients, based on the treatment timescale:

- Group A: life-threatening emergencies (shortness of breath, hemorrhage)

Immediate treatment is required. A screening encompassing RT-PCR detection of SARS-Cov-2 from nasopharyngeal swabs and chest CT-scan should ideally be done less than 24 hours before surgery. If this screening is impossible, the patient must be regarded as COVID positive and the appropriate precaution measures must be observed, in line with the protocol established in each center.

- Group B: cancers for whom postponing the treatment beyond one month could have a negative prognostic impact for the patient

Examples of such tumors are squamous cell cancers of the upper aerodigestive tract, aggressive cancers of the salivary glands, aggressive skin cancers.

If tracheostomy is not required, patient's management should not be delayed. All necessary investigations and treatments (scans, dental treatment before RT, PAC, etc.) should be performed during a single hospital stay in order to minimize patient's comings and goings between home and hospital. If treatment is impossible due to the local evolution of the COVID-19 pandemic, the patient should ideally be referred to another center specialized in head and neck cancer surgery

If tracheostomy is necessary, taking into account the high contamination risk of caregivers, the surgery should be postponed or a non-surgical alternative treatments should be chosen as far as possible.

- Group C: cancers for which the treatment can be postponed for at least 6 to 8 weeks without any significant prognostic impact

Examples of such tumors are well-differentiated thyroid cancers, non-progressive skin cancers such as basocellular cancers, some slow-growing cancers of the salivary glands, atypical nodules of the salivary glands which were not formally classified as malignant during the preoperative assessment, leukoplakia and superficial lesions of the vocal cords.

In such cases, the patient should be reassessed after 6 to 8 weeks in order to reconsider a rapid treatment according to the tumor growth velocity and evolution of the COVID-19 pandemic.

2.2. Consultations

Post-cancer treatment face-to-face follow-up consultations should be postponed as much as possible. Tele-consultations using phone or preferably video calls are recommended in order to detect symptoms compatible with a relapse. In such case, a face-to-face consultation should be scheduled.

Paraclinical exams prescribed as part of systematic follow-up, such as imaging, should be postponed.

New cases of cancer, symptomatic patients or treatment adjustments (examples: assessment after induction chemotherapy or first post-treatment assessment) require face-to-face consultations.

3. Organizational aspects

It is advisable to contact patients before they go to the hospital for consultation or surgery to check for signs of COVID-19 infection. If such signs exist, the patient should be referred to a COVID-19 diagnostic facility.

3.1. Consultations

The number of flexible naso-endoscopies and laryngoscopies should be limited as much as possible.

During any face-to-face consultation, the patient should be regarded as potentially COVID-positive, and the ENT specialist should wear an FFP2/N95 mask, a cap, a gown, protective goggles, and gloves. All disposable material must be eliminated through the infectious waste circuit.

3.2. Hospitalization and surgery

If possible, diagnostic work-up for COVID-19 should systematically be performed less than 24 hours before surgery (RT-PCR testing ± chest CT-scan).

In COVID-positive patients, surgery should possibly be postponed and the patient referred to a structure or a team specialized in the management of COVID-19.

3.3. Postponement of surgery

The decision to postpone a surgical procedure for head and neck cancer should be made on a case-by-case basis, by the surgical team and in agreement with the patient. Apart from the above-mentioned Group C, the final decision to postpone should ideally be taken during a Tumor Board Setting with a written report that should be sent to all the doctors involved in the patient's care.

The patient should be called by his ENT consultant who will explain the reason for the postponement, inform him or her of the probable delay before surgery and plan follow-up tele-consultations to consider moving the surgery forward in case of new symptoms or rapid tumor growth.

It is advisable to draw up a list of patients waiting for treatment, in order of priority.

It would also be advisable to set up a phone line or an email address that will allow the patient to contact the surgical team whenever needed.

Disclosure of interest

The authors declare that they have no competing interest.

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